Group Personal Accident Claim Form

Please print - Do not write

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THIS FORM IS REQUIRED IN ORDER TO ASSESS A PENDING CLAIM UNDER A POLICY OF INSURANCE. ISSUE AND COMPLETION OF THIS FORM DOES NOT IN ANY WAY IMPLY, CONSTRUE OR ADMIT LIABILITY BY THE COMPANY. ONLY A FULLY COMPLETED FORM CAN RECEIVE OUR CONSIDERATION.

Sections 1, 2, 3 and 4 are to be completed by the Insured Group or the Subsidiary claiming and Section 5 by the medical attendant. Please note that payment for any expenses incurred in the completion of this form is the responsibility of the claimant and not AIG South Africa Limited. Also note that we require the original medical accounts to support all claims for reimbursement of medical expenses. In the event that the claim is in respect of the shortfall after any medical aid payments then a copy of the statement from the Medical Aid Society is required.

1. GENERAL

Field	Entry
Name of insured group	
Name of subsidiary (if applicable)	
Policy number								
Names and surname of insured person	
Date of birth	D D M M Y Y
Occupation	
Date of accident	D D M M Y Y
Time	
Place	
Give a detailed description of how the accident occurred	

Insurance Fraudline
0860 002526
insurance@fraudline.co.za

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2. DEATH CLAIM

Date of death:	Place of death
State the exact cause of death and any important factors connected therewith	
THE FOLLOWING DOCUMENTS SHOULD BE PROVIDED AS IT BECOMES AVAILABLE:	
1. Certified copies of the abridged and the final death certificate	
2. A certified copy of the Post Mortem report	
3. A certified copy of the full Inquest Report including all witness statements pertaining thereto	
4. The police accident report if death was due to a motor accident.	
5. The police station and reference number if death is the subject of a criminal investigation.	
6. Copies of any newspaper clippings, eyewitness statements or incident reports that may be available.	

3. DISABILITY CLAIM

Give full details of the injuries sustained by the injured person
Please state the name, telephone number and address of the attending doctor.

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4. EMPLOYER'S CERTIFICATE
Full name of employer
Names and surname of the insured person
Category within which the insured person falls under the policy
Was the insured person in your direct employment or in that of a sub-contractor at the time of the accident
State fully the nature of the insured person's occupation and daily duties.
Stipulate the insured person's weekly/monthly earnings
Are any medical expenses or compensations payable in terms of a Workman's Compensation Act or by any other insurer.
YES ☐ NO ☐ (Tick the applicable box)
If YES, give full details

DECLARATION BY EMPLOYER	
I/We hereby warrant the truth of all the particulars on this form in every respect and declare that the conditions of this insurance have been complied with.	
Signature	Name in block letters
Date	Capacity
Company stamp	

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5. CERTIFICATE FROM INITIAL MEDICAL ATTENDANT

Full names and surname of patient	
Describe how the accident occurred	
Date of accident	Place of accident
Please state the exact cause and nature of the disability and any important factors connected therewith	
Does the present disability relate in any way to previous injuries or pre-existing conditions or illnesses YES ☐ NO ☐	
If YES, please elaborate	
Did any doctor other than you attend to the patient during the course of his /her disability YES ☐ NO ☐	
If YES, please state the name and address of any other attending doctor	
Name	
Address	
What is the probable date of stabilisation	
In your opinion what percentage of permanent disability can be ascribed to these injuries only	
Please state any information not already mentioned which might be relevant to the assessment of any permanent disability arising from the accident.	
Signature	Full names
Postal address	
	Postal code
Telephone number	